Opportunity Knocks: Opening Doorways to Medical Respite Care

Policy Update

March 13, 2013
CURRENT PRIORITIES

- Knowing the basics & educating others
- Facilitating outreach & enrollment & engagement in services
- Advocating for Medicaid expansion (if applicable)
- Participating in the health reform discussion
- Creating/strengthening partnerships
- Crafting specific requests based on demonstrated need
Where the **States** Stand: March 1, 2013

24 Governors Support Medicaid Expansion

[Map of the United States showing states participating in Medicaid expansion as of March 1, 2013.]

**Legend:**
- **Participating** 24
- **Leaning Toward Participating** 4
- **Undecided/No Comment** 5
- **Leaning Toward Not Participating** 3
- **Will Not Participate** 14
- **State-Run Exchange** 17
- **Partnership Exchange** 7
- **Federal-Run Exchange** 26

**Note:** Based on literature review as of 3/1/13. Policies are subject to change without notice. The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.


Learn more about the impact of the Supreme Court ruling at [advisory.com/MedicaidMap](http://advisory.com/MedicaidMap)
As of Sept. 2012:
10 yes
6 no
2011 Insurance Status: HCH v. All Health Centers v. U.S.

Sources: 2011 UDS Data, HRSA; 2011 Census Data
ENROLLMENT REQUIREMENTS

- No wrong door (online, phone, mail, in person)
- Electronic verification of income & identity
  - *No paper documentation*
- Coordinated Exchange, Medicaid & CHIP
- Timely processing
- Single, streamlined application
- No in-person interviews
- Automatic renewals every 12 months
- Use of modified adjusted gross income (MAGI)
- Enrollment assistance available
OUTREACH & ENROLLMENT

Law requires states “establish procedures for outreach and enrollment activities to vulnerable & underserved populations” (ACA § 2201)

- Children
- Unaccompanied homeless youth
- Children and youth with special health care needs
- Pregnant women
- Racial and ethnic minorities
- Rural populations
- Victims of abuse or trauma
- Individuals with mental health or substance-related disorders
- Individuals with HIV/AIDS
ELIGIBILITY OPTION

- **63 million currently enrolled**: children, pregnant women, disabled, and some parents of children

- **15 million newly eligible (starting January 1, 2014)**: Law gives states option to expand Medicaid to non-disabled adults earning ≤138% FPL
  - About $15,000/year for singles
  - About $25,500/year for family of 3

- **7.3 million currently eligible, un-enrolled**:
  - 4.4 million adults (67% take-up rate)
  - 2.9 million children (84% take up rate)

- **85 million possible Medicaid enrollees** (1 in 4)
CBO PROJECTED MEDICAID ENROLLMENT (NON-ELDERLY)

15 million adults newly eligible
CBO THOSE REMAINING UNINSURED

Remaining Uninsured:
37%: Medicaid-eligible but un-enrolled
25%: Undocumented/ineligible immigrants
NEED FOR CARE

- 7,200 new primary care providers needed (2.5% of the current supply)
  - Geographic disparities in level of disruption
  - 44 million (14%) live in areas where 5%+ increase in demand
  - 7 million (2%) live in areas where 10%+ increase in demand

Source: Huang and Finegold. (March 2013.) Seven Million Americans Live in Areas Where Demand For Primary Care May Exceed Supply by More than 10%. Health Affairs. http://content.healthaffairs.org/content/early/2013/02/19/hlthaff.2012.0913.full.pdf+html.

- Many with chronic and acute illnesses and behavioral health conditions
Characteristics of 18-64 Year-Olds Projected in Medicaid Expansion Population

MODELS OF CARE

- Integrated, team-based care (mental health, addictions, medical)
- Focus on quality and outcomes, not quantity of procedures
- Patient-centered medical homes
- Electronic health records
- Coordinated care across multiple venues
- Collect data, eliminate disparities
- Coordinated care entities/accountable care organizations, etc.
- Health care viewed in a wider perspective
  - Renewed attention to social determinants of health
ROLE OF RESPITE

- Follow-up hospital presumptive eligibility applications
- Ensure enrollment in a care plan
- Select/change appropriate provider
- Coordinate care transitions
- Patient education about care options, health insurance
- Informing public discussion
PARTNERSHIPS

- Hospitals (and hospital associations!)
  - CEO/CFO/Administrators
  - Emergency department lead
  - Social work/discharge lead

- Medicaid Director/Senior Staff
  - Payer for services
  - Significant pressure for cost-containment

- Local/State Health Officers
  - Public health implications
  - Use of local services/budget impacts
PARTNERSHIPS (cont’d)

- **Legislators/Council Members**
  - Health care
  - Health disparities
  - Poverty/homeless
  - Fiscal conservatives
  - Caucus members
  - Budget members

- **Governors/Mayors**
  - 10-Year Plans to End Homelessness
  - Budget concerns, impact on public services
  - Leverage federal funding

Great for introducing legislation, mandating reports, scheduling informational briefings, getting attention to issues.
PARTNERSHIPS (cont’d)

- **Judges/Specialty Courts**
  - Mental health/drug courts
  - Goal to reduce recidivism, engage in community care

- **Managed Care Organizations**
  - Key financial stakeholder
  - Wide range of flexibility for services and payment

- **Primary Care Associations**
  - Education, training and TA

- **Health Centers**
STATE PLANNING: AN OPPORTUNITY

- Creation of state health benefit exchanges
- Commissions/task forces/advisory committees
  - Focus on special populations, safety net providers
  - Go to the meetings
  - Sign up to testify
  - Take consumers and Board members
  - Get nominated to stakeholder groups

Health Care & Housing Are Human Rights
HCH COMMUNITY ADVOCACY AREAS

1. Medicaid expansion
2. Outreach
3. Insurance application
4. Provider selection
5. Cost sharing
6. Continuity of care
7. Workforce capacity
8. Available benefits
9. Insurance protocols
10. Remaining safety net
11. Housing
12. Further reform (universal health care)

Health Care & Housing Are Human Rights
YOUR SPECIFIC “ASKS”

- What specific, feasible action(s) do you want to happen?
- Are action(s) outlined in writing with all needed detail?
- Do you have the data (hard or soft) to justify these changes?
- Have you identified someone appropriate to champion your cause?
- Have you met individually—and in coalition—with numerous stakeholders?
**OPPORTUNITIES**

- Improved individual & public health
- Improved health care system
- Reduced personal bankruptcy & poverty
- Increased individual & family stability
- Increased employment & productivity
- Reduced recidivism to criminal justice
- Preventing & ending homelessness

**RISKS**

- Fail to reach newly/currently eligible (lack of outreach)
- Continued barriers to enrollment
- Inability to find provider(s)
- Difficulty engaging in care
- Ongoing housing instability risks engagement in care
- Poor transition to exchange jeopardizes gains in health, income
- Ongoing homelessness & poor health